



Changes to your health plan

Effective January 1, 2027, there will be some changes to your plan's costs and benefits. We are notifying you in advance so you can make informed decisions about your health coverage. Please visit blueshieldca.com/policies for updated terms and conditions of coverage.

Cost share changes

Copayment (or copay), coinsurance, and deductible are your share of the cost ("cost share") when using covered services. This section contains cost changes when using a participating provider, unless otherwise stated. Refer to your *Evidence of Coverage/Summary of Benefits* (EOC/SOB) for further details.

Calendar year out-of-pocket maximum changes

Description of change	What's changing?	
	2026 (this year)	2027 (renewal year)
Your calendar year out-of-pocket maximum has increased.	Individual/Family \$9,800/\$19,600	Individual/Family \$11,650/\$23,300

Participating pharmacy prescription drug cost share changes

Benefit section and description of change		What's changing?	
		2026 (this year)	2027 (renewal year)
Retail pharmacy prescription drugs Your copay for tier 1 drugs has decreased.	Tier 1 drugs	\$25/prescription, pharmacy deductible does not apply	\$15/prescription, pharmacy deductible does not apply
Retail pharmacy prescription drugs Your copay for tier 3 drugs has increased.	Tier 3 drugs	\$160/prescription, pharmacy deductible applies	50% up to \$500/ prescription, pharmacy deductible applies
Home delivery pharmacy prescription drugs Your copay for tier 1 drugs has decreased.	Tier 1 drugs	\$75/prescription, pharmacy deductible does not apply	\$45/prescription, pharmacy deductible does not apply
Home delivery pharmacy prescription drugs Your copay for tier 3 drugs has increased.	Tier 3 drugs	\$480/prescription, pharmacy deductible applies	50% up to \$1,500/ prescription, pharmacy deductible applies

Medical benefit cost share changes

Benefit section and summary of change	Benefit category	What's changing?	
		2026 (this year)	2027 (renewal year)
Physician services Your copay for these services has increased.	Trio+ specialist care office visit (self-referral)	\$85/visit	\$95/visit
	Other specialist care office visit (referred by PCP)	\$85/visit	\$95/visit
Other Professional services Your copay for these services has increased.	Acupuncture services	\$50/visit	\$65/visit
Diagnostic x-ray, imaging, pathology, and laboratory services The calendar year deductible applies.	Basic imaging services:		
	Outpatient department of a hospital	\$115/visit, medical deductible does not apply	\$115/visit, medical deductible applies
	Other outpatient non-invasive diagnostic testing:		
	Outpatient department of a hospital	\$115/visit, medical deductible does not apply	\$115/visit, medical deductible applies
Diagnostic x-ray, imaging, pathology, and laboratory services Your copay for these services has increased.	Advanced imaging services:		
	Outpatient radiology center	\$350/visit, medical deductible does not apply	50%, medical deductible applies
	Outpatient department of a hospital	\$350/visit, medical deductible applies	50%, medical deductible applies

Benefit changes and clarifications

Changes to your benefits/services will be reflected in your EOC/SOB.

NOTE: Underlines below indicate added text.

Benefit changes

These are changes made to your coverage for certain medical and pharmacy services.

Section name	Description of the change(s)
Notes: Outpatient prescription drug coverage	Added a cap on your cost share for insulin: "Insulin. You will not pay more than \$35 for a 30-day supply of formulary insulin prescription drugs from a participating pharmacy."
Preventive health services	As of January 1, 2025, we cover preventive care items and services recommended by the California Department of Public Health in addition to federal agencies, such as the United States Preventive Service Task Force (USPSTF).
Definitions: Intensive outpatient program	We increased coverage for intensive outpatient treatment of mental health or substance abuse disorders. Your plan used to cover up to nine hours a week, and now it may cover up to nineteen hours a week.
Mental health or substance use disorder benefits: Other outpatient mental health and substance use disorder services	The list of treatments that are not covered include the following: "Benefits do not include <u>treatment not supported by current Generally Accepted Standards of Mental Health and Substance Use Disorder Care, including:</u> • <u>Outdoor, youth, or wilderness programs and accommodations;</u> • <u>Equine assisted therapy;</u> • Treatment for the purpose of providing respite or day care; • <u>Educational services;</u> or • <u>Any other treatment or other facilities that provide primarily a supportive environment and address long-term social needs.</u> <u>In addition, benefits do not include reimbursement of a parent, legal guardian, or conservator for participation in such treatment or programs."</u>

Administrative/language clarifications

These are revisions made to your EOC/SOB to help make your coverage easier to understand, but do not impact your coverage or how your benefits/services work.

Section name	Description of the change(s)
Address change: Paying for coverage	The address for mailing premium payments has been updated to: Blue Shield of California P.O. Box 60532 City of Industry, CA 91716-0532
Mental health or substance use disorder benefits: Outpatient mental health and substance use disorder services	Revised to clarify that coverage includes: • <u>"Neuropsychological and psychological testing to diagnose a mental health condition and/or to assess the health of certain brain functions."</u>
Prescription drug benefits: Obtaining outpatient prescription drugs from the home delivery participating pharmacy	The terms "mail order pharmacy" or "mail service pharmacy" have been updated to "home delivery pharmacy."
Multiple sections	To adopt the state-regulated standardized template for plan documents (for example, the EOC), we (1) revised certain defined terms, (2) replaced the <i>Exclusions and limitations</i> section, and (3) replaced <i>Your bill of rights</i> and <i>Your responsibilities</i> sections.

Please note: This document is not a contract. For complete benefit descriptions, terms and conditions, exclusions, and limitations of the health plan, please read your EOC/SOB.